PRINTED: 07/07/2011

	F OF HEALTH AND HUN					ORM APPROVED
	R MEDICARE & MEDIC		AND MILITIDI E CO	NETRICTION		MB NO. 0938-0391
AND PLAN OF CORRECTION IDEN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155605	(X2) MULTIPLE CC A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/07/2011		LETED
	PROVIDER OR SUPPLIEF	EHABILITATION CENTER	1959 E	ADDRESS, CITY, STATE, ZIP CODE COLUMBUS ST NSVILLE, IN46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
K0000	State Licensure of the Indiana State accordance with Survey Date: 06 Facility Number Provider Number AIM Number: 1 Surveyor: Mark Code Specialist At this Life Safe Grandview Heal Center was foun Requirements for Medicare/Medicat	:: 000400 er: 155605 100266880 : Caraher, Life Safety	K0000	Submission of this plan of correction does not constitute admission or agreement by provider of the truth of facts alleged or corrections set for the statement of deficiencies plan of correction is prepare submitted because of requirement under state and federal law.Please accept the plan of correction as our creatilegation of compliance.	the orth on es.This ed and d his	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility has a capacity of 80 and had a

(X6) DATE

TITLE

000400

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA ((X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 01			COMPLETED		
		155605			06/07/20	6/07/2011		
			B. WING		DDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER					COLUMBUS ST			
GRANDVIEW HEALTH & REHABILITATION CENTER					SVILLE, IN46151			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	, i		P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	census of 65 at the	ne time of this visit.						
		Robert Booher, REHS, Life ist-Medical Surveyor on						
	The facility was	found not in compliance						
	with the aforeme	ntioned regulatory				e O6/24/2011 e re vas fety		
	requirements as o							
	following:	3						
	<i>S</i> .							
K0025 SS=E	least a one half hor accordance with 8 terminate at an atriprotected by fire-raglass panels and stwo separate compeach floor. Dampe penetrations of smheating, ventilating systems. 19.3.3.19.1.6.4 Based on observations facility failed to smoke barriers with the second part of the second paction part of the second part of the second part of the second pa	e constructed to provide at our fire resistance rating in a.3. Smoke barriers may rium wall. Windows are ated glazing or by wired steel frames. A minimum of partments are provided on ers are not required in duct noke barriers in fully ducted and air conditioning 7.3, 19.3.7.5, 19.1.6.3, ation and interview, the ensure 1 of 1 ceiling ras maintained to provide	K00	025	The facility will ensure this requirement is met through th following corrective measures:1. No residents we		06/24/2011	
	rating for the ceil rooms with natur heaters. This det affect any residen	f hour fire resistance ling in 1 of 2 mechanical ral gas fired water ficient practice could nt, staff or visitor in the echanical room by the on.			harmed. The smoke barrier of immediately fixed upon life sate exiting the building. The hole inthe ceiling was dry walled a painted. All other smoke bar were inspected and found to in-compliance. 2. All resider have the potential to be affect See below for corrective measures.3. The maintenant	was afety e and riers be nts cted.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DHOM21 Facility ID: 000400

If continuation sheet

Page 2 of 9

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		STRUCTION 01	(X3) DATE S COMPL	
		155605	B. WING			06/07/20	011
	ROVIDER OR SUPPLIER	HABILITATION CENTER		1959 E C	DRESS, CITY, STATE, ZIP CODE COLUMBUS ST SVILLE, IN46151		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
	Based on observation facility with the land of 106/07/11 from 1 the mechanical restation which confired water heater diameter opening attic above the massed on intervision observation, the lacknowledged the the east nurses' si	ation during a tour of the Maintenance Director on 1:45 a.m. to 1:40 p.m., com by the east nurse's ntains three natural gas rs had an eight inch g in the ceiling into the hiddle water heater.			supervisor was re-educated of the requirements of K0025. Aquality assurance monitoring has been implemented and who be completed weekly x 4 wks monthly x 3 months and quarthere after until compliance housen mainained for 2 consequarters. See attachment A. Findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of activationally accordingly.5. The above corrective measures we completed on or before 6/24/	A tool vill s and cterly as cutive 4. De	
K0029 SS=E	fire-rated doors) of extinguishing system and/or 19.3.5.4 properties of the system are separated from resisting partitions self-closing and not protective plates the from the bottom of 19.3.2.1	d construction (with 3/4 hour r an approved automatic fire em in accordance with 8.4.1 otects hazardous areas. It d automatic fire em option is used, the areas in other spaces by smoke and doors. Doors are on-rated or field-applied that do not exceed 48 inches if the door are permitted.	K00	29	The facility will ensure this requirement is met through the	ne	06/24/2011

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		LDING	01	COMPLETED		
155605		155605	B. WIN			06/07/2	011	
NAME OF F				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER	<u>C</u>		1959 E	COLUMBUS ST			
GRANDVIEW HEALTH & REHABILITATION CENTER					NSVILLE, IN46151			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	following corrective measure	0.1	DATE	
	<u>-</u>	ensure 2 of 2 doors			No residents were harmed.	5. 1.		
	_	is areas such as laundry			Immediatly following life safe	ety		
		ped with self closing			surveyor exit, new door	-		
		oor which securely			closures were installed on bo			
		loor frame. This deficient			doors and repaired the doors	s to		
	•	fect any resident, staff or			working condition. 2. All residents have the potential	to be		
	visitor in the vici	inity of the laundry room.			affected. See below for corrective measures.3. The	lo be		
	Findings include	:			maintenance supervisor will re-educated on the requirem	ents		
	Based on observ	ations during a tour of the			of K0029. A quality insurance monitoring tool will be compl			
		Maintenance Director on			weekly x 4 wks then monthly			
	_	1:45 a.m. to 1:40 p.m., the			months and quarterly until	Α σ		
		rridor door by Room # 12			compliance has been mainta	ined		
	The state of the s	a self closing device but	for two consecutive quarters. See attachment B.4. The					
		nd latch securely into the			See attachment B.4. The findings of these audits will be			
		laundry room corridor			reviewed during the facility's	, C		
		facility exit is not			quarterly Quality Assurance			
		self closing device but			meeting and the plan of action	n		
		y into the door frame.			adjusted accordingly.5. The			
	Based on intervi				above corrective measures v completed on or before June			
					2011.	: 24,		
	· ·	Maintenance Director			==			
	_	e laundry room corridor						
	_	12 self closed but did not						
		or frame, and the laundry						
		oor by the east facility exit						
	is not equipped v	with a self closing device.						
	3.1-19(b)							
K0038 SS=F		anged so that exits are at all times in accordance 19.2.1						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155605 06/07/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1959 E COLUMBUS ST **GRANDVIEW HEALTH & REHABILITATION CENTER** MARTINSVILLE, IN46151 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Based on observation and interview, the K0038 The facility will ensure this 07/01/2011 requirement is met through the facility failed to ensure 7 of 7 exit door following corrective electromagnetic locks remained unlocked measures:1. No residents were while the fire alarm was activated. LSC harmed. Immediatley following the life safety exit, Koorsen's Fire 19.2.1 requires every aisle, passageway, and security were called and corridor, exit discharge, exit location, and came to the facilty to check the access to be in accordance with Chapter 7. exit doors and alarming system. LSC 7.2.1.6(a) requires doors with special On 6/28/11 Koorsens sent locking arrangements such as proposal for a latching relay. 2. All residents have the potential to electromagnetic locks to unlock upon be affected. See below for actuation of an approved fire alarm corrective measures.3. Koorsens system installed in accordance with LSC educated the maintence director 9.6. LSC 9.6.1.4 requires a fire alarm on the life safety doors. See attachment C. Koorsens to system to be installed, tested and provide and install latching relay maintained in accordance with NFPA 72, and normally closed reset button the National Fire Alarm Code. NFPA 72, to trigger existing fire door relay. This will latch and stay latched 3-9.7.2 requires all emergency exits keeping the fire doors unlocked connected to the fire alarm system unlock until reset button is activiated. upon receipt of any fire alarm signal by Therefore silencing the panel will the fire alarm system serving the protected not release fire door relay. premises. This deficient practice affects Maintance will monitor with the quality assurance audit tool all residents, staff and visitors. weekly x 4 weeks, monthly x 3 months and quarterly until 2 Findings include: consecutive quarters are in compliance. See attachment D. 4. The findings of these audits Based on observations during a tour of the will be reviewed during the facility with the Maintenance Director on facility's quarterly Quality 06/07/11 from 11:45 a.m. to 1:40 p.m., Assurance meetings and the plan all seven facility exit doors are equipped of action adjusted accordingly.5. The above corrective measures with electromagnetic locks which will be completed on or remained locked when the fire alarm was before 7/1/11. activated and silenced, but not reset at 1:15 p.m. Based on interview at the time of observation, the Maintenance Director

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DHOM21

Facility ID:

000400

If continuation sheet

Page 5 of 9

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155605	(X2) MULT A. BUILDI B. WING		O1	(X3) DATE S COMPL 06/07/20	ETED
	PROVIDER OR SUPPLIER	HABILITATION CENTER	1	959 E C	DDRESS, CITY, STATE, ZIP CODE COLUMBUS ST SVILLE, IN46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
	electromagnetic unlocked when the activated, then ret the system was s 3.1-19(b)	mained unlocked when ilenced but not reset.					
K0076 SS=E	are protected in ac Standards for Head Standards for Head Standards for Standards for He	e locations of greater than closed by a one-hour upply systems of greater re vented to the outside.	K007	76	The facility will ensure this requirement is met through the following corrective measure. No residents were harmed. All residents have the potentiabeing affected. A tarping system was installed to protect the oxygen tanks from all weather conditions. 3. The maintenant supervisor was re-educated of the requirements of K0076. A quality assurance montioring has been implemented and we be completed weekly x 4 wks	s:1. 2. ial of stem er nce on A tool	06/24/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
155605		IDENTIFICATION NUMBER:	A. BUIL	DING	01	06/07/2	
		133003	B. WINC			00/07/2	011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
GRANDVIEW HEALTH & REHABILITATION CENTER					ISVILLE, IN46151		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	COMPLETION
TAG			+	TAG	·	etls (DATE
	·	the sun in those localities			monthly x 3 months and quarters of until 2 consecutive quarters of	•	
		emperatures prevail. This			compliance are maintained.		
	•	e could affect any			attachment E. 4. Findings of		
		visitor in the vicinity of			these audits will be reviewed		
	, , ,	gen supply location near			during the facility's quarterly		
	the exit of the fac	cility by Room #112.			Quality Assurance meetings the plan of action adjusted	and	
					accordingly. 5. The above		
	Findings include	:			corrective measures will be		
					completed on or before 6/24/	'11.	
	Based on observa	ation during a tour of the					
	facility with the	Maintenance Director on					
	06/07/11 from 1	1:45 a.m. to 1:40 p.m.,					
	seven 180 liter li	quid oxygen tanks were					
		rior chain link enclosure					
	outside the facili	ty near the exit by Room					
		osure was not protected					
		or rain. Based on					
		time of observation, the					
		ector acknowledged					
		orage tanks in the exterior					
		torage location were					
	exposed to all ty	_					
	exposed to all ty	pos or wounter.					
	3.1-19(b)						
	2.1 17(0)						
K0144		spected weekly and					
SS=F	exercised under lo	pad for 30 minutes per					
	3.4.4.1.	IOO WILLIAM I A 33.					
	• • • • • • • • • • • • • • • • • • • •	review and interview, the	K0	144	The facility will ensure this		06/24/2011
		provide complete			requirement is met through the		
	documentation for	-			following corrective measure		
		rators providing power to			No residents were harmed.2 residents have the potential t		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

I 155605		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
			- 1	LDING	01	06/07/2011
		100000	B. WIN		DDDEGG CITY CTATE ZIR CODE	00/01/2011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE COLUMBUS ST	
GRANDV	GRANDVIEW HEALTH & REHABILITATION CENTER			1	NSVILLE, IN46151	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	affected. See below for	DATE
		ghting systems. LSC			corrective measures.3. A ne	w l
		A 99, Health Care			form was initiated to ensure	
	· ·	1.8 requires the generator sufficient capacity to pick			compliance with the generate	
		neet the minimum			transfer time of 10 seconds. form will be utilized on all rou	
	frequency and vo				maintance inspections of the	
		the emergency system			generator and the maintenar	
	*	s after loss of normal			supervisor was educated on use of the form. See attachr	
		cient practice could			F. 4. The findings of these	
	-	ts, staff and visitors.			audits will be reviewed during	g the
		,			facility's quarterly Quality	-1
	Findings include				Assurance meeting and the polynomial of action adjusted	oian
					accordingly. 5. The above	
	Based on review of the "Generator Log				corrective measures will be	
		" documentation with the			completed on or before 6/24/	/11.
		ector during record				
	review from 9:58	8 a.m. to 11:45 a.m. on				
	06/07/11, the em	nergency generator was				
	run on a monthly	basis for at least thirty				
	minutes each mo	nth for the period of				
	12/02/10 through	05/24/11 but the the				
	logs utilized by t	he facility did not record				
		er power from the main				
		ergency generator. Based				
		ne time of record review,				
		Director acknowledged				
	the transfer time to transfer power to the					
		rator was not recorded for				
	each month.					
	2.1.10(1.)					
	3.1-19(b)					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155605 (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING				COM 06/07	(X3) DATE SURVEY COMPLETED 06/07/2011	
GRAND\		EHABILITATION CENTER	1959 E MARTII	ADDRESS, CITY, STATE, ZIP C COLUMBUS ST NSVILLE, IN46151	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	